2012 WL 8968614 (Ky.Cir.Ct.) (Trial Filing)
Circuit Court of Kentucky,
Division Eleven(11).
Jefferson County

Gail Griffin SMITH, as Executrix of the Estate of David W. Griffin, Deceased, Plaintiff,
v.
THE THIRD AND OAK CORPORATION, d/b/a Treyton Oak Towers, Defendant.

No. 09-CI-009816.
January 24, 2012.

Plaintiff's Memorandum of Law and Fact

Brain M. Vines, Attorney for Plaintiff.

Of Counsel: Matthew C. Minner, Esquire, Donald P. McKenna, Esquire, Brian M. Vines, Esquire, Hare, Wynn, Newell and Newton, LLC, 2025 Third Avenue North; Suite 800, Birmingham, Alabama 35203, Telephone: 205/328-5330, Facsimile: 205/324-2165.

Comes now the Plaintiff, pursuant to this Court's scheduling order, and submits Plaintiff's memorandum of law and fact, along with a statement of foreseeable legal and factual issues. The memorandum sets forth a concise statement of the facts as well as the law applicable to the claims at issue.

SUMMARY OF CLAIMS

This action involves the negligent care and treatment of Dr. David Griffin on or about September 24, 2008, while a resident of Treyton Oak Towers. Gail Griffin Smith, as Executrix of the Estate of Dr. David Griffin has brought suit against the Third and Oak Corporation d/b/a Treyton Oak Towers (“TOT”) for the negligence, gross negligence, wantonness, **abuse** and neglect of TOT in causing the fracture of Dr. Griffin's right fibula and tibia bones. Defendant's actions and omissions, violated both Kentucky and Federal laws governing the care of **elderly** patients. Plaintiff also seeks punitive damages under Kentucky's nursing home laws for the following: TOT's deliberate cover-up and concealment of the injury to Dr. Griffin, the indifference displayed for the right and safety of tohers and the TOT employee conduct surrounding the injury; failure to report the injury to appropriate State authorities; violation of Kentucky and Federal laws governing care of the **elderly** that permit the imposition of punitive damages; and to punish the wrongful conduct of TOT and to deter TOT and other similarly situated providers from engaging in such conduct in the future.

SUMMARY OF THE FACTS

A. Background and The Injury

Dr. David Griffin, a retired surgeon, was a resident of Treyton Oak Towers from December 2002 through the end of September 2008. Dr. Griffin's wife Yvonne was also a resident of Treyton Oak Towers beginning in 2004 until she was transferred to another nursing home in October 2008 following the injuries to Dr. Griffin.

By the year 2008, Dr. Griffin had suffered a series of strokes limiting his physical abilities. He was unable to walk. He had muscle contractures in both his arms and legs. He required total care and support to move and transfer him from one location to

another. Dr. Griffin had to be physically transferred from his bed to a Geri-chair so that he could be wheeled to the dining room. He has to be transferred from his bed or chair to the shower. He has to be transferred to the toilet. In sum, anytime Dr. Griffin needed to be moved from one location to another, he needed nurses and nursing assistants to physically move him. Further, Dr. Griffin's physical condition made him unable to assist nurses while they were transferring him. In other words, he could not hold on to things or control his limbs. Because of Dr. Griffin's total dependence and special movement needs, his care plan contained instructions on how he was to be safely moved to protect him from harm. Dr. Griffin's Care Plan specified that he was to be moved with a Hoyer lift with the assistance of two persons. The TOT Care Plan required that such transfer be done by mechanical lift (Hoyer) with two person assistance.

On or about September 25, 2008, Dr. Griffin was discovered with impact fractures to his right fibula and tibia. No caretaker at TOT reported the fractures at the time they occurred. No caretaker at TOT noted an injury or incident to Dr. Griffin in his medical record or before on September 25, 2008. However, the testimony of TOT nurses and certified nursing assistants ("CNAs") is that on the night of September 24 2008, CNA Lupe Bell was in a hurry to get Dr. Griffin in his bed and down for the night. Rather than waiting on her fellow CNA to assist her with the transfer of Dr. Griffin, Lupe Bell violated the Care Plan and attempted to transfer Dr. Griffin by herself and had problems in doing so. Dr. Griffin, because of his prior strokes, was unable to speak or cry out for help.

B. Discovery of the Injury by Others

On September 25, 2008, Dr. Griffin was noted by to have redness, swelling and blistering on his lower right leg. As the external condition of Dr. Griffin's leg continued to grow worse, Dr. O'Brien (TOT Medical Director) ordered an x-ray of Dr. Griffin's leg. The x-ray revealed a fracture of Dr. Griffin's right tibia described by Dr. O'Brien as an impact fracture. Dr. Griffin was then transferred from TOT to Jewish Hospital where a better x-ray revealed a fracture of his right fibula as well.

Dr. Griffin was also receiving palliative care from Hosparus. When Hosparus care giver, Carol Teske, saw the condition of Dr. Griffin's leg and received no explanation from TOT as to how the injury occurred, she notified Adult Protective Services.

C. Transfer to Presbyterian Nursing Home

Upon learning of the fractures, talking to Dr. O'Brien and members of Dr. Griffin's Hosparus care team, Dr. Griffin's daughters decided not to return him to Treyton Oak Towers. Dr. Griffin was transferred from Jewish Hospital to Presbyterian Nursing Home on October 3, 2008. Dr. Griffin's wife was transferred from TOT to Prebyterian about the same time.

D. Adult Protective Services Investigation Finds Caretaker Neglect

The Adult Protective Services Agency of the Commonwealth of Kentucky conducted an investigation of Dr. Griffin's injury at TOT. The investigation was led by Russell Price with the assistance and consultation of RN Imogene Neikirk. They each conducted interviews with the direct care givers for Dr. Griffin and reviewed all relevant medical records. The investigators found evidence of caretaker neglect in that the nurses did not transfer Dr. Griffin according to the requirements of his care plan. The report also found that this caretaker neglect likely led to the injury of David Griffin. The investigators also discovered a broad systematic breakdown of staff and their understanding of care to be given to residents such that Adult Protective Services also found caretaker neglect against TOT as a whole.

E. TOT's Cover-Up and Concealment

Treyton Oak Towers took substantial actions to cover up and conceal the injuries to Dr. Griffin and TOT's neglect and **abuse** of Dr. Griffin. The cover up began when no one at TOT noted the incident or injury to Dr. Griffin in his medical record when

it happened or anytime thereafter. Once the fractures were discovered by x-ray, Director of Nursing, Katrinka Whitney had all of the nurses and CNAs responsible for care to Dr. Griffin provide written statements of their knowledge concerning the injuries and regarding how Dr. Griffin was to be transferred. When Katrinka Whitney did not like the content of a particular caregiver's statement, she changed it by either crumbling it up and having the person write a new statement that conformed to what she wanted the statement to say, or by throwing away the caregivers handwritten statement and providing a changed type-written statement for the caregiver to sign. These acts of concealment by the D.O.N. Katrinka Whitney are supported the testimony of former employees Sarah Hickerson and Jahmecia Morris. Further, evidence of cover-up and concealment comes from Dr. Griffin's Hosparus nurse Carol Teske. Ms. Teske testified that she told Katrinka Whitney that she needed to report Dr. Griffin's "unexplained" injury to Adult Protective Services as required by law. Katrinka Whitney refused to do so and encouraged Carol Teske and Hosparaus not to report the injury to APS. Additional evidence of cover-up and concealment comes from APS registered nurse consultant Imogene Neikirk. Ms. Neikirk testified that Katrinka Whitney was uncooperative and obstructive to the APS investigation.

F. TOT's Lack of Adequate Training of Staff Led to Improper Care for Patients

TOT failed to adequately train, monitor, supervise and evaluate its employees as required by the applicable regulations. Testimony of many TOT nurses and CNAs revealed that they did not receive required annual evaluations while at TOT. The annual evaluations are required so that deficiencies can be discovered and corrective training given. The failure to evaluate and train employees as required by the regulations manifested itself in the TOT nurses' and CNAs' inability to interpret, understand, and carry out resident care plans. Numerous TOT nurses and CNA's were deposed about Dr. Griffin's care plan requirements. Their interpretations and understandings of the care plan requirements were in significant conflict, particularly with regard to how Dr. Griffin was to be transferred. Some nurses and CNAs testified that he was to be transferred with two people and a hoyer lift. Others testified that he could be transferred with one person and a hoyer lift. Still other testified that he could be transferred by two persons manually lifting him. D.O.N. Katrinka Whitney told APS that all of her staff knew that he was to be transferred via a hoyer with two assistants. That testimony has not changed.

APPLICABLE LAW

In addition to the general principles of negligence, gross negligence and wantonness, specific Kentucky and Federal laws and regulations govern the care of the **elderly**. The following laws and regulations are applicable to the case *subjudice.*

A. KRS 216.515 (6), (18), (19), (22) Rights of Residents - Duties of Facilities - Actions

• Every resident in a long-term care facility shall have at least the following rights:
• The right to be free from physical and mental **abuse**;

• The right to be treated with consideration, respect and full recognition of his dignity, including privacy in treatment and in care for his personal needs; • The right to have his family member informed of his medical condition; • The right to have his responsible family member notified immediately of any accident, sudden illness, disease, unexplained absence or anything unusual involving the resident.

B. 42 CFR § 483 sets forth Federal requirements for Long Term Care Facilities and has the following applicable requirements and rights of patients.

• The resident has a right to a dignified existence.

• A facility must immediately inform the resident; consult with the resident's physician; and if known, the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health status in either life-threatening conditions or clinical complications).

• The facility must record and periodically update the address and phone number of the resident's legal representative or interested family members.

• The resident has the right to be free from verbal, sexual, physical and mental **abuse**.

• The facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

• The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect.

• Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being.

• The facility must ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal hygiene.

• The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident received adequate supervision and assistance devices to prevent accidents.

• The facility must ensure that residents are free of any significant medication errors.

• The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

• The facility must ensure that all nursing staff receive evaluations and the proper training based on deficiencies revealed in evaluations.

• The facility must provide services by sufficient numbers of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.

• The facility must provide routine and emergency drugs to its residents.

• The facility must he administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

• The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

• The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible.

• The clinical record must contain sufficient information to identify the resident, a record of the resident's assessments, progress notes and the plan of care and services provided.

C. 42 C.F.R. § 483.13 Resident behavior and facility practices.

These are additional regulations particularly applicable to the facts of this case and the reporting of Dr. Griffin's injury.

(c)(2) The facility must ensure that all alleged violations of mistreatment, neglect or **abuse**, including injuries of unknown sources, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(c)(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.

D. KRS 209.010, 209.020 and 209.030.

These are the Kentucky regulations governing reporting suspected **abuse** or neglect of adults by caretakers. In pertinent part these regulations provide:
• Any person ... having reasonable cause to expect an adult has been **abused** or suffered neglect shall report or cause reports to be made to the cabinet immediately either orally or in writing.

• A caretaker shall not **abuse** an adult by the infliction of physical pain, mental injury or injury.

• A caretaker shall not neglect an adult by the deprivation of services which are necessary to maintain the health and welfare of an adult.

E. 922 KAR 5:070 is applicable to the Adult Protective Services Investigation of Dr. Griffin's injuries and the TOT facility.

F. 902 KAR 20:026 is applicable to the Operations and Services of a Skilled Nursing Facility such as Treyton Oak Towers. The Kentucky long term care regulations at issue include but are not limited to:
1. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services outside the facility.

2. A facility must protect and promote the rights of each resident.

3. The facility shall record and periodically update the address and phone number of the resident's legal representative or interested family member.

4. The resident shall have the right to be free from physical or mental **abuse**.

5. A facility shall care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect.

6. When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

7. The services provided or arranged by the facility shall meet professional standards of quality.

8. Each resident shall receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status.

9. Each resident shall receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

10. The facility shall ensure that each resident receives adequate supervision and assistive devices to prevent accidents.

11. The facility shall ensure that residents are free of any significant medication errors.

12. The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental well-being of each resident.

13. The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents:

a. Licensed Nurses

b. Other nursing personnel

14. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

15. The facility shall operate and provide services in compliance with all applicable federal, state and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in a facility.

16. The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurate documented, readily accessible, and systematically organized.

17. The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.

18. The facility shall have adequate personnel to meet the needs of the patients on a 24 hours basis.

19. The number and classification of personnel required shall be based on the number of patients and the amount and kind of personal care, nursing care, supervision and program needed to meet the needs of the patients.

20. Each record shall include a medication sheet which contains the date, time given, name of each medication dosage and name of person who administered the medication and Nurse's note indicating changes in patient's condition, mode and frequency of PRN medications administered, reactions following PRN medications and phone calls to the physician.

21. There shall be 24-hour nursing service with a sufficient number of nursing personnel on duty at all times to meet the total needs of patients.

22. Sufficient nursing time shall be available to assure that each patient shall receive treatments, medication and diets as prescribed; proper care to be kept comfortable, clean and well-groomed; protected from accident and injury and treated with kindness and respect.

Respectfully submitted this 23rd day of January, 2012.

<<signature>>

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